DSS
Strong Families - South Dakota's Foundation and Our Future

Site Accreditation Report – East Central Behavioral Health

Completed: October 9-10, 2018

Levels of Care Reviewed:

Substance Use Disorder (SUD) Services

Outpatient Services

Mental Health (MH) Services

Outpatient Services
Child and Youth or Family Services (CYF)
Comprehensive Assistance with Recovery and Empowerment Services (CARE)

Review Process: East Central Behavioral Health was reviewed by Division of Behavioral Health staff for adherence to the Administrative Rules of South Dakota (ARSD) and Contract Attachments. The following information was derived from the on-site accreditation survey of your agency. This report includes strengths, recommendations, and citations for Plans of Corrections and results from reviewing policies and procedures, personnel and case file records, and conducting interviews with clients, administration, and agency staff.

Administrative Review Score: 75%
Combined Client Chart Review Score: 76.7%
Cumulative Score: 76.6%

ADMINISTRATIVE REVIEW SUMMARY

Strengths: The agency has a director with open communication to staff members and the board of directors. The staff reported positive feedback regarding the change in leadership. Staff report feeling supported by the leadership team as they encourage the staff to attend trainings and continue in their professional development. The staff reported recently they feel they have been given more direction regarding policies and procedures. The agency's policy and procedure manual is individualized and specific to East Central Behavioral Health. The board of directors meets monthly which exceeds expectations of the required quarterly meetings. The agency is rebuilding their relationships with the school and other organizations within the community the agency serves by having regular meetings with stakeholders.

Recommendations:

1. The client rights form needs to be updated to reflect the current ARSD 67:61:06:02 and 67:62:07:02. The new rules went into effect in Dec. 2016. One of the six guaranteed client rights should be added to clearly identify all client rights. The following client right from the Rule needs to be added:

    iv. To have access to an advocate as defined in subdivision ARSD 67:61:01:01(4) or an employee of the state's designated protection and advocacy system;

2. The prevention program shall encompass current research, theory, and practice-based strategies and activities implemented through structured prevention strategies according to ARSD 67:61:11:01. There was no evidence that the prevention plan was approved by the boards of directors or director. It is recommended that the approval of the structured prevention plan is documented in the board minutes.

3. The contract attachment 1 requires agencies to publicize priority services for pregnant women, women with dependent children and IV users. The prioritized service needs to be documented. Agencies also need a policy for Limited English Proficient (LEP). While the team was onsite these policies were created and reviewed by the DBH.

Plan of Correction:
The following areas will require a plan of correction to address the rules of non-compliance which shall include an updated policy and/or procedure, a time frame for implementation of this procedure, the staff position or title responsible for implementation and the staff position or title responsible for ensuring continued compliance of these rules.

1. Each agency shall develop root cause analysis policies and procedures to utilize in response to sentinel events according to ARSD 67:61:02:21 and 67:62:02:19. Each agency shall report to the division within 24 hours of any sentinel event including: death not primarily related to the natural course of the client's illness or underlying condition, permanent harm or severe temporary harm and intervention required to sustain life. The agency did not have a sentinel event policy and a policy will need to be developed.

2. The agency must submit accurate statistical data on each client receiving services to the division in a manner agree upon by the division and the agency per ARSD 67:61:04:02 and 67:62:05:02. The agency has not been submitting outcome tools into STARS and will need to complete the tools to ensure compliance with the 60% expected return rate.

3. According to ARSD 67:61:06:07, each agency shall have a discharge policy that constitutes reason for discharge at staff request; the procedure for the staff to follow when discharging a client involved in the commission of a crime on the premises of the program or against its staff, the procedure for the staff to follow when a client leaves against medical or staff advice, prohibition against automatic discharge for any instance of non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness; and procedure for referrals for clients with symptoms of mental illness or a medical condition and those requesting assistance to manage symptoms. The agency did not have a discharge policy and one will need to be developed.

4. The agency's program director shall review and approve all electronic, written, and printed materials intended for public distribution for validity, relevancy, and appeal. Additionally an agency that conducts classroom or group educational programs shall use a structured evidence-based curriculum for prevention education. The review of all public distribution materials and prevention curriculums being implemented shall be made available for review by agency staff, the public, and the division in an electronic or printed format per ARSD 67:61:11:05. Materials used in the prevention program were not being signed off by the director and no distribution materials were available during the review.

5. According to ARSD 67:61:11:08, the agency needs to conduct quality assurance reviews of its prevention program to monitor, protect, and enhance the quality and appropriateness of its

programming and to identify qualitative problems and recommends plans for correcting each problem. The agency needs to conduct:

i. Annual satisfaction surveys of all individuals or stakeholders who requested and participated in prevention services;
iii. Pre- and post-tests for all evidence based curricula presented to individuals

The agency needs to complete an annual summary of the above reports and make them available to the board of directors or agency staff and to the division and community members upon request. Ensure these elements are completed and an annual summary is available to be in compliance with the rule.

6. According to ARSD 67:61:05:05 and 67:62:06:04, the agency shall provide orientation for all staff, including contracted staff providing direct clinical services, interns, and volunteers within ten working days after employment and document all elements of ARSD within the orientation process. In review of the personal files, orientation was not found to be completed within ten days of hire. The agency will need to develop a procedure to ensure orientation is completed in the required ten day time frame.

7. According to ARSD 67:61:05:04, agency staff providing prevention programming must complete the Substance Abuse Prevention Skills Training (SAPST) or Foundations of Prevention within one year of hires. There was no evidence of completion of either training in the personal records of the staff providing prevention programming. The staff should ensure they attend a SAPST training or Foundations of Prevention when available.

8. According to ARSD 67:61:05:01, a two-step Tuberculin skin test for new employees is required, with one-step occurring within 14 days of the date of hire and the second step within the first twelve months of employment. The documentation of the first required TB skin test was not completed within the 14 days of hire in the majority of the personnel records reviewed. The agency should develop a policy to ensure staff completes the TB test within 14 days of hire.

CLIENT CHART REVIEW SUMMARY

Strengths: The integrated assessments address trauma and domestic violence. The agency provides a place for CARE clients to go to throughout the day to socialize with others. The counselors are thorough in completing their supplemental documentation as the charts all include financial eligibility forms and releases of information. The clients interviewed reported the front office staff to be friendly and professional.

Recommendations:

1. According to ARSD 67:62:08:11, transition planning shall be provided to clients moving to a different service, leaving services, or for youth nearing adulthood. Goals related to transition planning shall be included in the clinical documentation either as part of the treatment plan or as a separate transition plan. In review of the CYF, mental health outpatient, and CARE charts it was difficult to tell if the clients' transition plans were completed. It is recommended the agency completes transition plans for clients to be in full compliance of the rule.

Plan of Correction:
The following areas will require a plan of correction to address the rules of non-compliance which shall include an updated policy and/or procedure, a time frame for implementation of this procedure, the staff position or title responsible for implementation and the staff position or title responsible for ensuring continued compliance of these rules.

1. According to ARSD 67:61:07:05 and 67:62:08:05, SUD and MH assessments shall contain the following:
    - Strengths of the client and the client's family if appropriate, as well as previous periods of success and the strengths that contributed to that success. Identification of potential resources within the family, if applicable;
    - Identification of readiness for change for problem areas, including motivation and supports for making such changes;
    - Educational history and needs
    - Past or current indications of trauma or domestic violence or both if applicable;
    - Behavioral observations or mental status, for example, a description of whether affect and mood are congruent or whether any hallucinations or delusions are present;
    - Eligibility determination for SMI or SED for mental health services or level of care determination for substance use services, or both if applicable;
    - Clinical supervisor's signature, credentials, and date verifying review of the assessment and agreement with the initial diagnosis or formulation of the initial diagnosis in cases where the staff does not have the education and training to make a diagnosis;

    The agency should ensure all of the above required elements are addressed when assessments are completed even when one or more topic is not applicable to a particular client, so it is clear that all elements are addressed. In addition, all integrated assessments need to be completed within 30 days of first meeting with the client. It is recommended to place an initial start date at the top of the assessment to be clear the assessment was completed within 30 days of onset of services.

2. In review of the SUD outpatient treatment plans, nine out of ten charts reviewed were missing evidence of the clients' meaningful involvement in formulating the treatment plan. In review of the CYF, CARE and MH outpatient charts, all of the charts reviewed were missing one or more of the required elements for treatment plans. Per ARSD 67:61:07:06 and 67:62:08:07. The following elements were missing in one or more of the treatment plans:

    - Contain either goals or objectives, or both, that are individualized, clear, specific, and measurable in the sense that both the client and the mental health staff can tell when progress has been made;
    - Include treatment for multiple needs, if applicable, such as co-occurring disorders that are relevant to the client's mental health treatment;
    - Include interventions that match the client's readiness for change for identified issues;
    - Be understandable by the client and the client's family if applicable;
    - Mental health staff signature, credentials, and date are documented;
    - Clinical supervisor's signature, credentials, and date are documented if the mental health staff does not meet the criteria of a clinical supervisor;

- The plan is completed within 30 days of intake
- Evidence of the client's meaningful involvement in formulating the plan must also be documented in the file.

Furthermore, it was found that the treatment plan goals need to be individualized to the client. It is also recommended that if the client has more than one concern that a problem and goal is created to help the client to address all of the concerns. Clients interviewed report they were unaware they had a treatment plan and were not involved in creating the treatment plan. The agency needs to ensure all required elements are completed for treatment plans and that clients are involved in creating their treatment plan to be in full compliance with the rule.

3. In review of the CYF charts, three out of three charts reviewed were missing one or more of the required elements in treatment plan reviews. In review of the CARE treatment plan reviews, three out of the five charts reviewed were missing one or more of the required elements per ARSD 67:62:08:08. Treatment plan reviews need to contain the following elements:
    - Treatment Plan is reviewed at a minimum of six month intervals;
    - Treatment Plan Review contains a written review of any progress made or significant changes to goals or objectives (Reviews can be documented in progress notes and changes to goals or objectives must be documented on the Treatment Plan);
    - Justification for continued need for mental health services is documented;
    - Staff signature, credentials, and date of review are documented.

    The agency needs to ensure all required elements are documented in the treatment plan reviews.

4. According to ARSD 67:62:08:09, clinical supervisors shall conduct one treatment plan review at least annually. In review of CYF and CARE charts; two out of the six charts reviewed did not have supervisor reviews completed annually. The agency needs to ensure that supervisory treatment plan reviews are completed annually by clinical supervisors on all mental health charts.

5. A crisis intervention plan shall be provided to any client who has safety issues, risks, or has frequent crisis situations or recurrent hospitalizations according to ARSD 67:62:08:10. In review of the CYF, MH outpatient, and CARE charts; five charts appeared to need a crisis intervention plan that was not found within the chart. They agency needs to ensure a crisis intervention plan is developed upon completion of the treatment plan, if needed. The crisis plan should be individualized and client focused.

6. In review of the SUD outpatient progress notes, seven out of twelve charts reviewed were missing one or more of the required elements for progress notes. In review of the CYF progress notes, six out of the eight charts reviewed were missing a brief description of what the client and provider plan to work on during the next sessions, including work that may be occurring between sessions. In review of the MH outpatient progress notes, six out of the six charts reviewed were missing one or more of the required elements for progress notes. In review of the CARE progress notes, five out of the nine charts reviewed were missing one or more of the required elements according to ARSD 67:61:07:08 and 67:62:08:12. Progress notes need to contain the following elements:
    - Each client's case record shall record and maintain a minimum of one progress note weekly to document counseling sessions with the client, which substantiate all services provided, and summarize significant events occurring throughout the case management process;

- A brief assessment of the client's functioning;
- A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues to achieve identified treatment goals or objectives;
- A brief description of what the client and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and
- The signature and credentials of the staff providing the service.

In addition, the progress notes at times appeared to be vague and not individualized to the client. The plan for the next week was repeated throughout the chart. The progress notes were vague when describing the client's functioning. It is also recommended the agency complete non-billable notes to show how the client is progressing or not progressing in treatment.

7. In review of the SUD charts, seven of the nine charts reviewed were missing one of more the elements for a transfer or discharge summary. In review of the MH charts, ten of the eleven charts reviewed were missing one or more of the required elements for a transfer or discharge summary. A transfer or discharge summary shall be completed upon termination or discontinuation of services within five working days according to ARSD 67:61:07:10 and 67:62:08:14. In review of SUD, CYF, mental health outpatient, and CARE charts one or more of the following requirements were missing:

    - A transfer or discharge summary completed within five working days;
    - A transfer or discharge summary on the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan must be maintained in the client case record;
    - If client prematurely discharges from services, reasonable attempts are made and documented to re-engage client into services.

    The agency needs to ensure that all elements are completed to be in compliance with this rule and that the discharge summary is completed within five working days.

8. According to ARSD 67:61:07:12 Tuberculin screening requirements**,** a designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment within 24 hours of admission to determine if the client has had any of the following symptoms within the previous three months:

    - Productive cough for a two to three week duration;
    - Unexplained night sweats;
    - Unexplained fevers; or
    - Unexplained weight loss.

    In review of the agency's SUD charts seven out of the fifteen charts did not have the TB screen completed within 24 hours of admission. The charts did contain the questions; however, were not completed. The agency will need to ensure the questions are completed within 24 hours in order to be in compliance with the rule.